illegal immigrant in the performance of this Contract. The Contractor shall reaffirm this attestation, in writing, by submitting to the State a completed and signed copy of the document as Attachment C, hereto, semi-annually during the period of this Contract. Such attestations shall be maintained by the contractor and made available to state officials upon request.

b. Prior to the use of any subcontractor in the performance of this Contract, and semi-annually thereafter, during the period of this Contract, the Contractor shall obtain and retain a current, written attestation that the subcontractor shall not knowingly utilize the services of an illegal immigrant to perform work relative to this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant to perform work relative to this Contract. Attestations obtained from such subcontractors shall be maintained by the contractor and made available to state officials upon request.

c. The Contractor shall maintain records for all personnel used in the performance of this Contract. Said records shall be subject to review and random inspection at any reasonable time upon reasonable notice by the State.

d. The Contractor understands and agrees that failure to comply with this section will be subject to the sanctions of Public Chapter 878 of 2006 for acts or omissions occurring after its effective date. This law requires the Commissioner of Finance and Administration to prohibit a contractor from contracting with, or submitting an offer, proposal, or bid to contract with the State of Tennessee to supply goods or services for a period of one year after a contractor is discovered to have knowingly used the services of illegal immigrants during the performance of this contract.

e. For purposes of this Contract, "illegal immigrant" shall be defined as any person who is not either a United States citizen, a Lawful Permanent Resident, or a person whose physical presence in the United States is authorized or allowed by the federal Department of Homeland Security and who, under federal immigration laws and/or regulations, is authorized to be employed in the U.S. or is otherwise authorized to provide services under the Contract.

D.9 Records. The Contractor shall maintain documentation for all charges against the State under this Contract. The books, records, and documents of the Contractor, insofar as they relate to work performed or money received under this contract, shall be maintained for a period of three (3) full years from the date of the final payment and shall be subject to audit at any reasonable time and upon reasonable notice by the State, the Comptroller of the Treasury, or their duly appointed representatives. The financial statements shall be prepared in accordance with generally accepted accounting principles.

D.10 Monitoring. The Contractor's activities conducted and records maintained, pursuant to this Contract, shall be subject to monitoring and evaluation by the State, the Comptroller of the Treasury, or their duly appointed representatives.

D.11 Progress Reports. The Contractor shall submit brief, periodic, progress reports to the State as requested.

D.12 Strict Performance. Failure by any party to this Contract to insist in any one or more cases upon the strict performance of any of the terms, covenants, conditions, or provisions of this Contract shall not be construed as a waiver or relinquishment of any such term, covenant, condition, or provision. No term or condition of this Contract shall be held to be waived, modified, or deleted except by a written amendment signed by the parties hereto.

D.13 Independent Contractor. The parties hereto, in the performance of this Contract, shall not act as employees, partners, joint ventures, or associates of one another. It is expressly acknowledged by the parties hereto that such parties are independent contracting entities and that nothing in this Contract shall be construed to create an employer/employee relationship, or to allow either to exercise control or direction over the manner or method by which the other transacts its business affairs or provides its

usual services. The employees or agents of one party shall not be deemed or construed to be the employees or agents of the other party, for any purpose whatsoever.

The Contractor, being an independent contractor, and not an employee of the State, agrees to carry adequate public liability and other appropriate forms of insurance, including adequate public liability and other appropriate forms of insurance on the Contractor's employees, and to pay all applicable taxes incident to this Contract.

State further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Contractor and that neither the Blue Cross Blue Shield Association nor any other Blue Cross Blue Shield licensee shall be considered to be a party to this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Contractor other than those obligations created under other provisions of this Contract.

On behalf of itself and its participants, the State hereby acknowledges its understanding that this Agreement constitutes a contract solely between the State and Contractor which is an independent corporation operating under a license from the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield Plans (the "Association") permitting Contractor to use the BlueCross and BlueShield Service Marks in the State of Tennessee, and that Contractor is not contracting as the agent of the Association.

Contractor is responsible for providing administrative claims payment services in accordance with the terms of the Plan, its duties and services as described in Attachment D, AccessTN Benefit Summary, and other duties specifically assumed by it pursuant to this Contract. Contractor does not assume any financial risk or obligation with respect to Plan claims.

D.14 State Liability. The State shall have no liability except as specifically provided in this contract.

D.15 Force Majeure. The obligations of the parties to this contract are subject to prevention by causes beyond the parties' control that could not be avoided by the exercise of due care including, but not limited to, acts of God, riots, wars, strikes, epidemics or any other similar cause.

D.16 State and Federal Compliance. The Contractor shall comply with all applicable State and Federal Laws and regulations in the performance of this contract.

D.17 Governing Law. This Contract shall be governed by and construed in accordance with the laws of the State of Tennessee. The Contractor agrees that it will be subject to the exclusive jurisdiction of the courts of the State of Tennessee in actions that may arise under this Contract. The Contractor acknowledges and agrees that any rights or claims against the State of Tennessee or its employees hereunder, and any remedies arising therefrom, shall be subject to and limited to those rights and remedies, if any, available under *Tennessee Code Annotated*, Sections 9-8-101 through 9-8-407.

D.18 Completeness. This Contract is complete and contains the entire understanding between the parties relating to the subject matter contained herein, including all the terms and conditions of the parties' agreement. This Contract supersedes any and all prior understandings, representations, negotiations, and agreements between the parties relating hereto, whether written or oral.

D.19 Severability. If any terms and conditions of this Contract are held to be invalid or unenforceable as a matter of law, the other terms and conditions hereof shall not be affected thereby and shall remain in full force and effect. To this end, the terms and conditions of this Contract are declared severable.

D.20 Headings. Section headings of this Contract are for reference purposes only and shall not be construed as part of this Contract.

E SPECIAL TERMS AND CONDITIONS

E.1 Conflicting Terms and Conditions. Should any of these special terms and conditions conflict with any other terms and conditions of this Contract, these special terms and conditions shall control.

E.2 Communications and Contacts. All instructions, notices, consents, demands, or other communications required or contemplated by this Contract shall be in writing and shall be made by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below or to such other party, facsimile number, or address as may be hereafter specified by written notice.

The State:

Marlene D. Alvarez, Manager of Procurements and Contracting
Tennessee Department of Finance & Administration
Division of Insurance Administration
312 Eighth Ave. No., 13th Floor WRS Tennessee Tower
Nashville, TN 37243-0295
Phone: 615-253-8358
Fax: 615-253-8556
Email Address: marlene.alvarez@state.tn.us

The Contractor:

Ms. Amy Bercher, Senior Product Manager
BlueCross BlueShield of Tennessee, Inc.
801 Pine Street – 4G
Chattanooga, TN 37402
Phone: 423-535-5983
Fax: 423-535-7601
E-mail Address: amy_bercher@bcbst.com

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the day of delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the telefax machine at the receiving location and receipt is verbally confirmed by the sender if prior to 4:30 p.m. CST. Any communication by facsimile transmission shall also be sent by United States mail on the same date of the facsimile transmission.

E.3 Subject to Funds Availability. The Contract is subject to the appropriation and availability of State and/or Federal funds. In the event that the funds are not appropriated or are otherwise unavailable, the State reserves the right to terminate the Contract upon written notice to the Contractor. Said termination shall not be deemed a breach of Contract by the State. Upon receipt of the written notice, the Contractor shall cease all work associated with the contract. Should such an event occur, the Contractor shall be entitled to compensation for all satisfactory and authorized services completed as of the termination date. Upon such termination, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.4 Breach. A party shall be deemed to have breached the Contract if any of the following occurs:

— failure to perform in accordance with any term or provision of the Contract;
— partial performance of any term or provision of the Contract;
— any act prohibited or restricted by the Contract, or
— violation of any warranty.

For purposes of this contract, these items shall hereinafter be referred to as a "Breach."

a. Contractor Breach— The State shall notify Contractor in writing of a Breach.

(1) In event of a Breach by Contractor, the State shall have available the remedy of Actual Damages and any other remedy available at law or equity.

(2) Liquidated Damages (hereafter referenced as "Performance Guarantee Assessments", as contained **in Contract Attachment A, Performance Guarantees** — In the event of a Breach, the State may assess Performance Guarantee Assessments. The State shall notify the Contractor of amounts to be assessed. The parties agree that due to the complicated nature of the Contractor's obligations under this Contract it would be difficult to specifically designate a monetary amount for a Breach by Contractor as said amounts are likely to be uncertain and not easily proven. Contractor hereby represents and covenants it has carefully reviewed the Performance Guarantee Assessments contained in above referenced, Attachment A, and agree that said amounts represent a reasonable relationship between the amount and what might reasonably be expected in the event of Breach, and are a reasonable estimate of the damages that would occur from a Breach. It is hereby agreed between the parties that the Performance Guarantee Assessments represent solely the damages and injuries sustained by the State in losing the benefit of the bargain with Contractor and do not include any injury or damage sustained by a third party. The Contractor agrees that the Performance Guarantee Assessment amounts are in addition to any amounts Contractor may owe the State pursuant to the indemnity provision or other section of this Contract.

The State may continue to assess Performance Guarantee Assessments or a portion thereof until the Contractor cures the Breach, the State exercises its option to declare a Partial Default, or the State terminates the Contract. The State is not obligated to assess Performance Guarantee Assessments before availing itself of any other remedy. The State may choose to discontinue Performance Guarantee Assessments and avail itself of any other remedy available under this Contract or at law or equity; provided, however, Contractor shall receive a credit for said Performance Guarantee Assessments previously assessed except in the event of a Partial Default.

(3) Partial Default— In the event of a Breach, the State may declare a Partial Default. In which case, the State shall provide the Contractor written notice of: (1) the date which Contractor shall terminate providing the service associated with the Breach; and (2) the date the State will begin to provide the service associated with the Breach. Notwithstanding the foregoing, the State may revise the time periods contained in the notice written to the Contractor.

In the event the State declares a Partial Default, the State may withhold, together with any other damages associated with the Breach, from the amounts due the Contractor the greater of: (1) amounts which would be paid the Contractor to provide the defaulted service; or (2) the cost to the State of providing the defaulted service, whether said service is provided by the State or a third party. To determine the amount the Contractor is being paid for any particular service, the Department shall be entitled to receive within five (5) days any requested material from Contractor. The State shall make the final and binding determination of said amount.

The State may assess Performance Guarantee Assessment amounts, as applicable, against the Contractor for any failure to perform which ultimately results in a Partial Default with said Performance Guarantee Assessment amounts to cease when said Partial Default is effective. Upon Partial Default, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount. Contractor agrees to cooperate fully with the State in the event a Partial Default is taken

(4) Contract Termination— In the event of a Breach, the State may terminate the Contract immediately or in stages. The Contractor shall be notified of the termination in writing by the State. Said notice shall hereinafter be referred to as Termination Notice. The

Termination Notice may specify either that the termination is to be effective immediately, on a date certain in the future, or that the Contractor shall cease operations under this Contract in stages. In the event of a termination, the State may withhold any amounts which may be due Contractor without waiver of any other remedy or damages available to the State at law or at equity. The Contractor shall be liable to the State for any and all damages incurred by the State and any and all expenses incurred by the State which exceed the amount the State would have paid Contractor under this Contract. Contractor agrees to cooperate with the State in the event of a Contract Termination or Partial Takeover.

b. State Breach— In the event of a Breach of contract by the State, the Contractor shall notify the State in writing within 30 days of any Breach of contract by the State. Said notice shall contain a description of the Breach. Failure by the Contractor to provide said written notice shall operate as an absolute waiver by the Contractor of the State's Breach. In no event shall any Breach on the part of the State excuse the Contractor from full performance under this Contract. In the event of Breach by the State, the Contractor may avail itself of any remedy at law in the forum with appropriate jurisdiction; provided, however, failure by the Contractor to give the State written notice and opportunity to cure as described herein operates as a waiver of the State's Breach. Failure by the Contractor to file a claim before the appropriate forum in Tennessee with jurisdiction to hear such claim within one (1) year of the written notice of Breach shall operate as a waiver of said claim in its entirety. It is agreed by the parties this provision establishes a contractual period of limitations for any claim brought by the Contractor.

E.5 Partial Takeover. The State may, at its convenience and without cause, exercise a partial takeover of any service which the Contractor is obligated to perform under this Contract, including but not limited to any service which is the subject of a subcontract between Contractor and a third party, although the Contractor is not in Breach (hereinafter referred to as "Partial Takeover"). Said Partial Takeover shall not be deemed a Breach of Contract by the State. Contractor shall be given at least 30 days prior written notice of said Partial Takeover with said notice to specify the area(s) of service the State will assume and the date of said assumption. Any Partial Takeover by the State shall not alter in any way Contractor's other obligations under this Contract. The State may withhold from amounts due the Contractor the amount the Contractor would have been paid to deliver the service as determined by the State. The amounts shall be withheld effective as of the date the State assumes the service. Upon Partial Takeover, the Contractor shall have no right to recover from the State any actual, general, special, incidental, consequential, or any other damages whatsoever of any description or amount.

E.6 Incorporation of Additional Documents. Included in this Contract by reference are the following documents:

a. The Contract document and its attachments
b. All Clarifications and addenda made to the Contractor's Proposal
c. The Request for Proposal and its associated amendments
d. Technical Specifications provided to the Contractor
e. The Contractor's Proposal

In the event of a discrepancy or ambiguity regarding the Contractor's duties, responsibilities, and performance under this Contract, these documents shall govern in order of precedence detailed above

E.7 Confidentiality of Records. Strict standards of confidentiality of records shall be maintained in accordance with the law. All material and information, regardless of form, medium or method of communication, provided to the Contractor by the State or acquired by the Contractor on behalf of the State shall be regarded as confidential information in accordance with the provisions of State law and ethical standards and shall not be disclosed, and all necessary steps shall be taken by the Contractor to safeguard the confidentiality of such material or information in conformance with State law and ethical standards.

The Contractor will be deemed to have satisfied its obligations under this section by exercising the same level of care to preserve the confidentiality of the State's information as the Contractor exercises

to protect its own confidential information so long as such standard of care does not violate the applicable provisions of the first paragraph of this section.

The Contractor's obligations under this section do not apply to information in the public domain; entering the public domain but not from a breach by the Contractor of this Contract; previously possessed by the Contractor without written obligations to the State to protect it; acquired by the Contractor without written restrictions against disclosure from a third party which, to the Contractor's knowledge, is free to disclose the information; independently developed by the Contractor without the use of the State's information; or, disclosed by the State to others without restrictions against disclosure.

It is expressly understood and agreed the obligations set forth in this section shall survive the termination of this Contract.

E.8 HIPAA Compliance. The State and Contractor shall comply with obligations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

a. Contractor warrants to the State that it is familiar with the requirements of HIPAA and its accompanying regulations, and will comply with all applicable HIPAA requirements in the course of this contract.
b. Contractor warrants that it will cooperate with the State, including cooperation and coordination with State privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of the Contract so that both parties will be in compliance with HIPAA.
c. The State and the Contractor will sign documents, including but not limited to business associate agreements, as required by HIPAA and that are reasonably necessary to keep the State and Contractor in compliance with HIPAA. This provision shall not apply if information received by the State under this Contract is NOT "protected health information" as defined by HIPAA, or if HIPAA permits the State to receive such information without entering into a business associate agreement or signing another such document. See Attachment 6.1.1.

E.9 Tennessee Consolidated Retirement System. The Contractor acknowledges and understands that, subject to statutory exceptions contained in ***Tennessee Code Annotated***, Section 8-36-801, *et. Seq.*, the law governing the Tennessee Consolidated Retirement System (TCRS), provides that if a retired member of TCRS, or of any superseded system administered by TCRS, or of any local retirement fund established pursuant to ***Tennessee Code Annotated***, Title 8, Chapter 35, Part 3 accepts state employment, the member's retirement allowance is suspended during the period of the employment. Accordingly and notwithstanding any provision of this Contract to the contrary, the Contractor agrees that if it is later determined that the true nature of the working relationship between the Contractor and the State under this Contract is that of "employee/employer" and not that of an independent contractor, the Contractor may be required to repay to TCRS the amount of retirement benefits the Contractor received from TCRS during the period of this Contract.

E.10 Debarment and Suspension. The Contractor certifies, to the best of its knowledge and belief, that it and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal or State department or agency;
b. have not within a three (3) year period preceding this Contract been convicted of, or had a civil judgment rendered against them from commission of fraud, or a criminal offence in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or Local) transaction or grant under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification, or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State, or Local) with commission of any of the offenses detailed in section b. of this certification; and
d. have not within a three (3) year period preceding this Contract had one or more public transactions (Federal, State, or Local) terminated for cause or default.

E.11 Contractor Commitment to Diversity. The Contractor shall comply with and make reasonable business efforts to exceed the commitment to diversity represented by the Contractor's proposal responding to

RFP # 317.40-044 (Attachment 6.3, Section B, Item B.13.) and resulting in this Contract.

The Contractor shall assist the State in monitoring the Contractor's performance of this commitment by providing, as requested, a quarterly report of participation in the performance of this Contract by small business enterprises and businesses owned by minorities, women, and persons with a disability. Such reports shall be provided to the state of Tennessee Governor's Office of Business Diversity Enterprise in form and substance as required by said office.

IN WITNESS WHEREOF:

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Ronald E. Harr — Feb. 21, 2007

RONALD E. HARR, SENIOR VICE PRESIDENT — **DATE**

Ronald E. Harr, Senior Vice President

PRINTED NAME AND TITLE OF CONTRACTOR SIGNATORY

ACCESS TENNESSEE BOARD OF DIRECTORS:

M. D. Goetz, Jr. — 2-23-07

M. D. GOETZ, JR., CHAIRMAN — **DATE**

APPROVED:

DEPARTMENT OF FINANCE AND ADMINISTRATION:

M. D. Goetz, Jr. — FEB 26 2007

M. D. GOETZ, JR., COMMISSIONER — **DATE**

per authorized signature above

COMPTROLLER OF THE TREASURY:

John G. Morgan — 2-28-07

JOHN G. MORGAN, COMPTROLLER OF THE TREASURY — **DATE**

Contract Attachment A
Performance Guarantees

The Contractor shall pay to the State the indicated total dollar assessment upon notification by the State that an amount is due, through the life of the contract.

1. Claims Payment Dollar Accuracy	
Guarantee	The average quarterly financial accuracy for claims payments will be 99% or higher.
Definition	Claims Payment Dollar Accuracy is defined as the absolute value of financial errors divided by the total paid value of Contractor audited dollars paid.
Assessment	**$800** for each full percentage point below 99% for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
2. Claims Processing Accuracy	
Guarantee	The average quarterly processing accuracy will be 95% or higher.
Definition	Claims Processing Accuracy is defined as the absolute number of State member claims with no in processing or procedural errors, divided by the total number of State member claims within the audit sample. This excludes financial errors.
Assessment	**$500** for each full percentage point below 95%, for each contracted quarter.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample of claims. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
3. Claims Turnaround Time	
Guarantee	The average quarterly claims payment turnaround time will not be greater than: • 14 calendar days for 90% of **non-investigated (clean)** claims; and • 30 calendar days for 96% of **all** claims
Definition	Claims Turnaround Time is measured from the date the claim is received in the office to the date processed, including weekends and holidays. Any claims that include COB and subrogation will be excluded when calculating compliance with the "investigated claims" performance standard.
Assessment	**Non-Investigated Claims (clean)**: **$100** for each full percentage point below the required minimum standard of 90% within 14 days. Quarterly Guarantee. **All Claims**: **$100** for each full percentage point below the required minimum standard of 96% within 30 days. Quarterly Guarantee.
Compliance report	The Compliance Report is the quarterly internal audit performed by the Contractor on a statistically valid sample. The Contractor shall measure and report results quarterly. Performance will be reconciled annually.
4. Telephone Response Time	
Guarantee	Ninety-five percent (95%) of incoming member services calls will be answered by a member services representative in 30 seconds or less.
Definition	Telephone Response Time is defined as the amount of time elapsing between the time a call is received into the phone system and when a live member services representative answers the phone.
Assessment	**$100** for each full second over the 30 second benchmark. Quarterly guarantee.
Compliance report	The Compliance Report is the Contractor's internal telephone support system reports. Performance will be measured quarterly; reported and reconciled annually.
5. Member Satisfaction	
Guarantee	The level of overall customer satisfaction, as measured annually by a State approved Member Satisfaction survey(s), will be equal to or greater than 85% in the second year of the Contract, and 90% in all subsequent year(s) within the contract term.
Definition	Member Satisfaction will be measured utilizing the most current National Committee on Quality Assurance (NCQA) Adult Member Satisfaction Survey question that measures overall satisfaction.
Assessment	**$5,000** for failure to attain an 85% satisfaction level for the measurement for the second calendar year

	of the contract and a 90% satisfaction level for each subsequent year of the contract. Satisfaction will be indicated by each neutral and each better than neutral response.
Compliance report	The Compliance Report is the Contractor's results from National Committee Quality Assurance (NCQA) annual Adult Member Satisfaction Survey. Performance will be measured, reported, and reconciled annually.

6. Provider/Facility Network Accessibility

Guarantee	As measured by the GeoNetworks® Provider & Facility Network Accessibility Analysis, the Contractor's provider and facility network will assure that 95% of all Plan members will have the Access Standard indicated.	
Definition	**Provider Group**	**Access Standard**
	PCPs (Endocrinologists, Internal Medicine, General or Family Practitioners)	2 physicians within 20 miles
	Acute Care Hospitals	1 facility within 30 miles
Assessment	**$1,000** if either of the characteristics of the network analysis are below the performance measure, as measured annually in December of each year of the contract.	
Compliance report	Compliance report is the annual GeoNetworks Analysis submitted by Contractor. The Annual guarantee is Measured, reported and reconciled annually.	

7. Claims Data Quality

Guarantee	Claims Data Quality is measured by the State's Claims Data Management vendor (Medstat). The Contractor's quarterly data submission to Medstat must meet the following Data Quality measures.	
Definition	*Measure*	*Benchmark*
	Gender	Data missing for </= (less than or equal to) 3% of claims
	Date of birth	Data missing for </= 3% of claims
	Outpatient diagnosis coding	Data invalid or missing for </= 5% of outpatient claims
	Outpatient provider type missing	Data missing for </= 1.5% of outpatient claims
Assessment	**$2500** if ANY of the above listed standards is not met, either individually or in combination. Quarterly Guarantee.	
Compliance report	Compliance Report consists of the MedStat Quarterly Data Quality report provided by MedStat. Performance measured and reported (by MedStat) quarterly; reconciled annually.)	

8. Member Handbooks, Provider Network Directories and Member ID Card Distribution

Guarantee	Member Handbooks, Porvider Network Directories and Member ID cards must be distributed (defined as "mailed") to a minimum of 99% of plan members within 14 calendar days of Enrollment.
Definition	The actual distribution to a minimum of 99% of plan members by the specified dates.
Assessment	Should the above standard not be met, the total amount shall be **$500** per year in which the standard is not met.
Compliance report	Compliance Report submitted by Contractor. Performance is measured, reported, and reconciled annually.

9. Submission of Quarterly Data to Data Management Vendor

Guarantee	Quarterly claims data will be submitted by the contractor to the state's data management vendor (MedStat) no later than the last day of the month following the end of each calendar quarter.
Definition	Quarterly claims data are received by MedStat no later than the last day of the month following the end of each calendar quarter.
Assessment	Failure to submit quarterly claims data no later than the last day of the month following the end of each quarter will result in an assessment of **$100** per day for the first and second working days past the compliance date, and $500 for each working day thereafter, to a maximum of **$3,000** per quarter.
Compliance report	Compliance reporting submitted by MedStat upon receipt of quarterly claims data. Performance is measured, reported, and reconciled quarterly.

10. Disease Management Program

Guarantee	Establish a disease management program as specified in item A.9.7 of the contract by the conclusion of the first four months of the contract and maintain a compliant program for each calendar year of the contract.

Definition	The operation of a qualified disease management program by the fourth month of the contract and during each of the calendar years of the contract, thereafter.
Assessment	Should the standard not be met by the fourth month of the contract, **$10,000** and during each of the subsequent calendar years of the contract, **$10,000** annually as reported by the contractor each December.
Compliance report	Submitted by the contractor, subject to examination of program content and participation by the State or the State's designee.

Contract Attachment B
Management Reporting Requirements

As required by Contract Section A.9, the Contractor shall submit Management Reports by which the State can assess the PPO program's general activity and usage, as well as treatment and success tendencies. Reports shall be submitted electronically and in hard copy format, and shall be of the type and at the frequency indicated below. Management Reports shall include:

1) **Performance Guarantee Tracking**, as detailed at Contract Attachment A (each component to be submitted at the frequency indicated), shall include:
   - Status report narrative
   - Detail report on each performance measure by appropriate time period

2) **Paid Claims Data by Quarter**, including 30 day run-out, and demonstrating Year-to-Date totals. All data should be broken out by Plan.
   - Number of Member Months
   - Total Paid Medical Expenses
   - Inpatient data:
     - Admissions per 1,000 members, for:
       - Medical/Surgical
       - Maternity
       - Other
       - Total
     - Days per 1,000 Members, for:
       - Medical/Surgical
       - Maternity
       - Other
       - Total
     - Average Length of Stay
   - Outpatient data:
     - Distribution of Dollars paid for Outpatient Services (expressed as percentages), for:
       - Medical
       - Surgery/ Diagnostic/Therapeutic
       - Anesthesia
       - Other
       - Total
   - Enrollment analysis, indicating:
     - Month 1, Month 2, Month 3 of the current quarter, and YTD, for:
       - Number of Members
       - Number of Patients
       - Average Age of Member
   - Prescription drug utilization- Retail and Mail Order:
     - Number of Prescriptions
     - Total Cost
     - Average Cost per Prescription
     - Average Cost per member per month
   - Top 10 Drugs by Number of Claims, demonstrating:
     - Drug Name
     - Number of Prescriptions
     - Brand Name or Generic
     - Allowed Ingredient Change
     - Allowed Quantity
     - Cost per Unit
   - Top 10 Drugs by Cost, demonstrating:
     - Drug Name
     - Number of Prescriptions
     - Brand Name or Generic
     - Allowed Ingredient Change
     - Allowed Quantity
     - Cost per Unit

3) **Quarterly Network Changes Update Report**, submitted electronically.

ATTESTATION RE PERSONNEL USED IN CONTRACT PERFORMANCE

SUBJECT CONTRACT NUMBER:	**FA-**
CONTRACTOR LEGAL ENTITY NAME:	**BlueCross BlueShield of Tennessee, Inc.**
FEDERAL EMPLOYER IDENTIFICATION NUMBER: (or Social Security Number)	**62-0427913**

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of this Contract and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of this Contract.

SIGNATURE & DATE: Ronald E. Harr, Feb. 21, 2007

NOTICE: This attestation MUST be signed by an individual empowered to contractually bind the Contractor. If said individual is not the chief executive or president, this document shall attach evidence showing the individual's authority to contractually bind the Contractor.

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "Medium"	Plan 5000 "Catastrophic"
This listing is for illustration only; plan documents shall control.	**Note: Benefits are subject to change by the AccessTN Board of Directors. Plan 500 'not currently offered.**	
PREVENTIVE CARE (first dollar- prior to deductible)	$300	$300
DEDUCTIBLES Individual Maximum Deductible per Plan Year – In network Out-of-network	$1,000 $2,000	$5,000 $10,000
Covered Expenses, as specified plan document , subject to maximum allowable charge	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Pre-Existing Conditions Period- except as stated for specific benefits, to be determined by Board of Directors	Underwritten based on 12 months	Underwritten based on 12 months
Prescription Drugs - Pharmacy does not apply to out of pocket maximum except for Plan 2,500 – HSA	No deductible for outpatient drugs	No deductible for outpatient drugs
[In addition to retail prices below, mail order program may offer incentive pricing, also to include willing network retail providers who contract to supply on same terms]	Copayment or coinsurance to be determined	Copayment or coinsurance to be determined
Generic	$10 copayment (or cost if less)	$15 copayment (or cost if less)
Preferred Brand Drugs	25% coinsurance subject to a min. of $25, max. of $50	30% coinsurance subject to a min. of $30, max. of $75
Non-Preferred Brand-	50% coinsurance subject to a min. of $50, max. of $100	60% copayment subject to a min. of $60, max. of $150
Non-covered Drugs	as identified by formulary	as identified by formulary
Maximum Out-of-Pocket Expense **(see criteria next page)**	$5,000	$10,000
Maximum Annual Benefits, except for supplemental **Organ Transplants as below**	$120,000	$100,000
Supplemental Maximum Benefit for Transplants	$100,000	$100,000
Maximum Lifetime Benefits Subject to prior benefits incurred in another state high risk pool(s)	$1,000,000	$1,000,000
Maximum Out-of-Pocket Expense No out of pocket maximum for out-of-network services No out of pocket maximum for pharmacy, except for Plan 2500, according to HSA regulations. No out of pocket max. for copays- emergency room visits	$5,000	$10,000
Covered Services includes		
Inpatient services- non-emergent service must be preauthorized	80% in-network 60% out-of-network	80% in-network 60% out-of-network

	Surgical Procedures Diagnostic Lab and Imaging Services Physician office visits Preventive care after first dollar allowance above Chemotherapy and Radiation Therapy Organ Transplant (designated procedures)	80% in-network 60% out-of-network	80% in-network 60% out-of-network
	Maternity benefits- Covered only under optional rider.	Not Covered	Not Covered

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "Medium"	Plan 5000 "Catastrophic"
Approved/Accredited Rehabilitation Facility		
Covered services listed below	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Inpatient Rehabilitation Facility		
Outpatient Rehabilitation Facility	Limited to 45 days per year	Limited to 45 days per year
Skilled Nursing Facility (Following approved hospitalization. Prior authorization required.)	Limited to 45 days per year	Limited to 45 days per year
Home Health Care	30 visits per year	30 visits per year
Non-Hospital & Non-Physician Services		
Independently Practicing Physical Therapists, Speech Therapists, Occupational Therapists, Dialysis Clinics, Oral Surgeons, or Audiologists	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Non-Contracted Providers (Varies based on the network/services area outside of Tennessee)		
Emergency Services (in-state or out-of-state)		
Emergency services (in -network or out-of-network) Note: Out-of-network benefits will be reduced to non-PPO levels if the claims administrator determines the situation was not an emergency.	80% of reasonable charges	80% of reasonable charges
Emergency Room Visit Copayment – waived if admitted ; Note: copayment required even if out-of-pocket expenses have been met, except HSA)	$50 copayment per visit	$75 copayment per visit
Non-Emergent Care		
Urgent Care Situations Urgent Care received at a walk-in clinic	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Urgent Care received through hospital emergency room (in addition to ER copay)	80% in-network 60% out-of-network	80% in-network 60% out-of-network
Appliances & Equipment Durable Medical Equipment	80% in-network 60% out-of-network $3,000 Annual Max	80% in-network 60% out-of-network $3,000 Annual Max
EXCLUSIONS **(This is a partial list- includes any services not medically necessary, etc.; see plan document for complete listing of exclusions.)**	**Cosmetic procedure** **Human Growth Hormone** **Hearing aids,** **Eyeglasses, contacts, etc.** **Dental services** **Routine foot care** **Maternity coverage, including routine newborn care**	

		Assisted reproductive technology, including fertility drugs **Services or supplies related to obesity, including surgical or other treatment for morbid obesity**

AccessTN OUTLINE OF PPO MEDICAL BENEFITS	Plan 1000 "Medium"	Plan 5000 "Catastrophic"
SCHEDULE OF PPO MENTAL HEALTH/ SUBSTANCE ABUSE BENEFITS		
DEDUCTIBLES- No separate Mental Health deductible	Outpatient services not subject to plan deductible	Outpatient services not subject to plan deductible
COINSURANCE **for MENTAL HEALTH/ SUBSTANCE ABUSE**	See below	See below
Inpatient – Including Intermediate Care Services (the preauthorization process must be followed or benefits are reduced to 50% of the MAC of the 80/60% levels)	80% in-network 60% out-of-network 30 days	80% in-network 60% out-of-network 30 days
Outpatient- In- Network Out-of-Network, subject to MAC [Note- Outpatient therapy sessions are NOT subject to plan deductible; inpatient above and intermediate levels below are subject to deductible.]	80% in-network 60% out-of-network 30 sessions	80% in-network 60% out-of-network 30 sessions
Expenses determined not to be medically necessary by the utilization review organization	$0	$0

Intermediate Care
All intermediate levels of care will be counted as inpatient for purposes of plan limitations.

- Residential Treatment: defined as a 24-hour level of residential care that is medically monitored, with 24-hour medical availability and 24-hour onsite nursing services. 1.5 residential treatment days = 1 inpatient day
- Partial Hospitalization: defined as structured and medically supervised day, evening and/or night treatment programs where program services are provided to patients at least 4 hours/day and are available at least 3 days/week, although some patients may need to attend less often.
  2 partial hospitalization days = 1 inpatient day
- Intensive Outpatient: defined as an intensive outpatient program, usually comprised of coordinated and integrated multidisciplinary services, having the capacity for a planned, structured, service provision of at least 2 hours per day and 3 days per week, although some patients may need to attend less often.
- 5 structured outpatient days = 1 inpatient day

Substance Abuse Limitations

- Lifetime maximum: Two inpatient stays – maximum of 28 days per stay. A stay is any substance treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 28 inpatient days.
- Lifetime maximum: Two inpatient stays for detoxification – maximum of 5 days per stay. A stay is any detox treatment counted as inpatient (including intermediate levels of care) where the duration is between 1 inpatient day and 5 inpatient days.

Additional Mental Health Limitations

- Inpatient care limit of 30 days per plan year (intermediate levels of care will be considered inpatient treatment for purposes of this limitation).
- Outpatient care limit of 30 visits per plan year is for mental health/substance abuse combined.

Payment is based on the MAC. Covered persons will be responsible for the deductible and any applicable copayment or coinsurance amounts. If non-network providers are used, covered persons will also be responsible for payment of charges above the Maximum allowable charge.

MEDSTAT STANDARD ELIGIBILITY FILE LAYOUT

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a monthly eligibility file for plan participants administered through **<Data Supplier>**.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

Data will be provided in a monthly file that reflects the status as of the end of the month, i.e. a "snapshot" as of a point in time. For example, if a project requires 36 months of historical data, Medstat will expect to receive 36 records for each member, one for each month. Ongoing file submissions would include one record for each member for the latest month only.

METHOD OF SUBMISSION

[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION

The data will be submitted to Medstat on a monthly basis.

TIMING OF SUBMISSION

Monthly files should be submitted on or before the 15th of the month following the close of each month.

SELECTION CRITERIA

Members and their dependents who are eligible for medical, prescription drug, mental health, hearing, dental, or vision coverage, as well as employees who have opted-out of coverage should be included. This includes one record for each participant and one record for each dependent for the reporting month. A record should be created if the person was eligible/enrolled at any time within the month (e.g. If an employee was terminated, there should be a record in the month of termination, but not in the subsequent month. The exception to this would be an employee who terminates but continues company-paid benefits under a severance plan).

Data should include:

- Covered active members and their covered dependents including retirees, surviving spouses/beneficiaries, LOA, LTD, STD, Permanent Disability, Military Leave, and FMLA.
- Employees who have opted-out of coverage

- Employees who have terminated but retain medical coverage through a severance plan paid by the company.
- COBRA enrollee information (if this information is being provided from this data supplier for the client).

Data need not include:

- It is not necessary to include employees and dependents who are not eligible for medical, prescription drug, mental health, hearing, dental, or vision coverage.
- Medstat would not want to receive information on terminated employees who do not continue company-paid benefits beyond the month of termination.
- If COBRA enrollee information will be supplied from a 3rd party, Medstat would ***NOT*** want to receive two records for one person.

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent $12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal).

POPULATION OF DATA ONTO DEPENDENT RECORDS

For certain fields, e.g. Family ID and Employee Status, we would like to have information copied down from the employee to the dependent record. For others, e.g. Gender or Date of Birth, we would like the data to be specific to the person. For financial

or quantity fields, (e.g. Employee Medical Contribution), to avoid over-counting, we would only want to see this information on the employee record.

For each field, Medstat has noted one of the three values below in the right-most column.

Member-specific = information relevant to the member (e.g. Date of Birth, Medstat would like each member's date of birth). Please populate on each record with the information specific to that member.

Employee-specific = information relevant to the employee/contract holder, but also **"copied down" to the dependent's record** (e.g. Family ID, Medstat would like the SSN of the employee also copied to each dependent's record).

Employee/Contract-Holder Only = information relevant to the employee/contract holder that Medstat would like on the **employee record or contract holder only**, i.e. not copied onto the dependent's records.

ELIGIBILITY LAYOUT – Detail Records

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	Population of Employee / Dependent Records
Standard Medstat Fields								
1	Record Type	1	1	1	Character	Record Type Identifier	Hard Code 'D'	Member-Specific
2	Business Unit Code	2	5	4	Character	Client-specific code for the business unit.	Business Unit values will be identified in the **Data Dictionary**.	Employee-Specific
3	Coverage Indicator Dental	6	6	1	Character	Indicator of Dental Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
4	Coverage Indicator Drug	7	7	1	Character	Indicator of Drug Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
5	Coverage Indicator Hearing	8	8	1	Character	Indicator of Hearing Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
6	Coverage Indicator Medical	9	9	1	Character	Indicator of Medical Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
7	Coverage Indicator MHSA	10	10	1	Character	Indicator of MHSA Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
8	Coverage Indicator Vision	11	11	1	Character	Indicator of Vision Coverage	Standard values: Y = Have coverage, N = Do not have coverage	Member-Specific
9	Coverage Tier Code	12	15	4	Character	Medical Coverage Tier Code	Customer-specific values.	Member-Specific
10	Date of Birth	16	25	10	Date	Birth date of the person	MM/DD/CCYY format	Member-Specific
11	Date of Eligibility Month	26	35	10	Date	First day of eligibility month	MM/DD/CCYY Format	Member-Specific
12	Employee Status Code	36	40	5	Character	Client-specific values of employee status.	Employee Status code values will be identified in the **Data Dictionary**.	Employee-Specific
13	Family ID	41	49	9	Character	Employee SSN		Employee-Specific
14	Gender	50	50	1	Character	Gender of the person.	M or F	Member-Specific
15	Employee Medicare Eligible Indicator	51	51	1	Character	A code indicating whether an employee is Medicare eligible.	Y = Yes N = No	Employee-Specific

16	Part-Time/Full-time Indicator	52	52	1	Character	A code indicating whether an employee is full-time or part-time.	P = Part-time F = Fulll-time	Employee-Specific
17	PCP Type Code	53	53	1	Character	A code indicating the Primary Care Physician's specialty or type ex. General Practice, Family Practice, OB/GYN	PCP Type code values will be identified in the **Data Dictionary**.	Member-Specific
18	PCP ID	54	66	13	Character	The provider identifier of the Primary Care Physician.	The Tax ID number for the provider is preferred.	Member-Specific
19	Plan Code	67	72	6	Character	The code for the medical plan in which the member is enrolled.	Plan code values will be identified in the **Data Dictionary**. It's desirable to have a plan code explicitly identifying "***Opt-outs***".	Member-Specific
20	Race Code	73	73	1	Character	A code specifying the race or ethnicity of the person.	Race code values will be identified in the **Data Dictionary.**	Member-Specific
21	Region Code	74	78	5	Character	Client-specific code for the geographic region of the person.	Region code values will be identified in the **Data Dictionary**.	Member-Specific
22	Relationship Code	79	83	5	Character	Client-specific values that specify the relationship of the member to the subscriber.	Relationship code values will be identified in the **Data Dictionary**.	Member-Specific
23	Salaried Indicator	84	84	1	Character	An indicator of whether the employee status is salaried or hourly.	Y = Salaried N = Hourly	Employee-Specific
24	Union Worker Indicator	85	85	1	Character	An indicator that the employee belongs to a union.	Y = Union N = Non-Union	Employee-Specific
25	Zip Code	86	95	10	Character	The zip code of the residence of the member at the time of the eligibility month.		Member-Specific
26	Monthly Employee Medical Contribution	96	105	10	Numeric	The monthly amount contributed by the employee for their medical benefits	Format 9(7)v99 (2 – digit, implied decimal) Only recorded on employee record (zero-filled on dependent records). Zero-filled for opt-outs.	Employee/Contract Holder Only
27	Monthly Medical Premium	106	115	10	Numeric	The employer-paid monthly premium for medical benefits (fully-insured plans)	Format 9(7)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid ***by the employer*** for fully-insured plans and not premium equivalents. ***<It should not be the net amount (minus employee contrib) as this will be calculated within the Medstat product.*** It should be populated only on employee records for those employees enrolled in fully-insured medical plans. On all other records	Employee/Contract Holder Only

							this field should be zero filled.	
28	Monthly Medical Admin Fees	116	125	10	Numeric	The employer-paid monthly admin/ASO fees for medical benefits (self-insured plans)	Format 9(7)v99 (2 – digit, implied decimal) This field is to be populated on employee records only for those employees enrolled in self-insured medical plans. For all other records, this field should be zero filled.	Employee/Contract Holder Only
Field Number	**Field Name**		**End**	**Length**	**Type**	**Data Element Description**	**Data Supplier Instructions/Notes**	**Population of Employee / Dependent Records**
Customer-specific fields								
<Add any Customer-specific fields here and adjust the field numbering and start/end positions accordingly>								
40	Filler1	178	299	122	Character	Reserved for future use	Fill with blanks	
41	Last Character	300	300	1	Character	Identification of last character in each row of data.	Hard Code 'Z'	

ELIGIBILITY LAYOUT – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction Notes	Population of Employee / Dependent Records
1	Record Type	1	1	1	Character	Record Type Identifier	Hard Code 'T'	N/A – only 1 trailer record will be provided.
2	Eligibility Start Date	2	11	10	Date	Eligibility Begin Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1st day of the month for which data is provided.	
3	Eligibility End Date	12	21	10	Date	Eligibility End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.	
4	Record Count	22	31	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record	
5	Filler	32	299	268	Character	Filler	Fill with Blanks	
6	Last Character	300	300	1	Character	Identification of last character in each row of data.	Hard Code 'Z'	

MEDSTAT STANDARD MEDICAL CLAIMS FILE LAYOUT

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a Medical claims file for plan participants administered through **<Data Supplier>**.
The data will be provided in a fixed-record length, ASCII file format. The data request consists of two layouts/records; A Medical Detail Record and a Trailer Record.

METHOD OF SUBMISSION

[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION

The data will be submitted to Medstat on a **<monthly/quarterly>** basis.

TIMING OF SUBMISSION

<Monthly/Quarterly> files should be submitted on or before the 15th of the month following the close of each **<month/quarter>**.

Data Type: Medical Claims / Encounter Records

Definitions:

- **Fee-for-service claims** – Claims records for services that result in direct payment to providers on a service-specific basis.
- **Encounter records** – Utilization records for services provided under capitation arrangements (i.e., plans in which a provider is paid based on the number of enrollees rather than the services rendered.) These records enable documentation of all services provided regardless of whether or not direct payment was made to the provider.
- **Facility Data** – Facility data includes all services rendered by an inpatient or outpatient facility. The basis for the requirements of facility data is the information found on the standard UB-92 claim form.
- **Professional Data** – Professional data includes all services rendered by a physician or other professional provider, including dental, vision and hearing. The basis for the requirements of professional data is the information found on the standard CMS-1500 claim form.
- **Fee-for-Service Equivalents** – Financial amounts for services rendered under a capitated arrangement found within encounter records.

Items for discussion

General

- If both fee-for-service claims and encounter records are included on the data file, Medstat will rely on the data supplier to explain how to differentiate them.
- Medstat prefers to receive the facility, professional and capitation data (if applicable) in one file. We will rely on the data supplier to explain how to differentiate facility, professional and capitation services in their data.
- If encounter records contain fee-for-service equivalents, it is essential for Medstat to understand which fields contain these amounts.
- Financial fields should be populated at the service line level, not at the claim level.
- Medstat will need to understand the circumstances under which claims are not paid on a line item basis. For example, situations where claims are paid on a per diem basis or paid based on a DRG.
- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

Financial Fields

Medstat defines the relationship among financial fields as follows:

Charge Submitted
– Not Covered Amount*
= Charge Covered*
– Discount Amount
= Allowed Amount
– Coinsurance
– Copayment
– Deductible
– Penalty/Sanction Amount*
– Third Party Amount
= **Net Payment**

*not required in standard data extract (desirable if available)

Corrections to paid claims

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Medstat defines these as follows:

Void/Replacement
A void is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it.
The original, void and replacement need not appear in the same file.

Example: After adjudication, a paid claim with a $25 Copay and $50 Net Pay, a correction was necessary. The correction contains a $10 Copay and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Void	-1	-75.00	-25.00	0.00	-50.00
Replacement	1	75.00	10.00	0.00	65.00

Adjustments

A financial adjustment is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well.
The original and adjustment need not appear in the same file.
Example: After a claim was adjudicated with a $25 Copay and $50 Net Pay, it was discovered that there should have been a $10 Copay and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Adjustment	0	0	-15.00	0.00	15.00

Facility Record Content

- The standard UB-92 claim form contains both information that pertains to the entire claim and single service/procedure within the claim.
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

Example: One facility claim with three service lines:

Claim-Level Information			Service-Level Detail			
Claim ID	Prov ID	Prov Type	Line Nbr	Rev Cd	Svc Cnt	Net Pay
11111	121212121	25	1	120	2	2000.00
11111	121212121	25	2	250	1	100.00
11111	121212121	25	3	720	10	1532.00

Professional Record Content

- Medstat does not store separate header/claim-level and detail/service-level information for professional claims. Medstat requires the following:
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim.)
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

Example: One professional claim with two service lines:

Claim-Level Information			Service-Level Detail			
Claim ID	Prov ID	Prov Type	Line Nbr	Proc Cd	Svc Cnt	Net Pay
13331	621262121	51	1	99201	1	100.00
13331	621262121	51	2	99175	1	150.00

Denied Claims

Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Medstat defines denied claims as follows:

- Fully denied claim - The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- Partially denied claim – The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

Data Type: Capitation Data

Definition

1 Capitation data contains information regarding payments made to a physician, facility or other provider for a pre-determined set of services, regardless if the services are rendered to the enrollee. When services are rendered, an encounter record will be found in the medical claims data.
Items for Discussion

- Person-level information is preferred; such as, one record contains payment information per person per month
- Provider detail information is also preferred

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent $12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal) and left zero-filled.

Medical Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Medstat Fields							
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Adjustment Type values will be identified in the **Data Dictionary.**
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
3	Bill Type Code UB	12	14	3	Character	The UB-92 standard code for the billing type, indicating type of facility, bill	Bill Type values will be identified in the **Data Dictionary.**
4	Capitated Service Indicator	15	15	1	Character	An indicator that this service (encounter record) was capitated	Applicable field values are "Y" for Capitated services and "N" for non-cap services.
5	Charge Submitted	16	25	10	Numeric	The submitted or billed charge amount	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
6	Claim ID	26	40	15	Character	The client-specific identifier of the claim.	
7	Claim Type Code	41	42	2	Numeric	Client-specific code for the type of claim	Claim Type Codes will be identified in the **Data Dictionary.**
8	Co-Insurance	43	52	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
9	Copayment	53	62	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 -- digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
10	Date of Birth	63	72	10	Date	The birth date of the person.	MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.

11	Date of First Service	73	82	10	Date	The date of the first service reported on the claim or authorization record.	MM/DD/CCYY format
12	Date of Last Service	83	92	10	Date	The date of the last service reported on the claim or authorization record.	MM/DD/CCYY format
13	Date of Service Facility Detail	93	102	10	Date	The date of service for the facility detail record.	MM/DD/CCYY format
14	Date Paid	103	112	10	Date	The date the claim or data record was paid.	MM/DD/CCYY format This is the check date.
15	Days	113	118	6	Numeric	The number of inpatient days for the facility claim.	
16	Deductible	119	128	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
17	Diagnosis Code Principal	129	133	5	Character	The first or principal diagnosis code for a service, claim or lab result.	No decimal point.
18	Diagnosis Code 2 UB	134	138	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
19	Diagnosis Code 3 UB	139	143	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
20	Diagnosis Code 4 UB	144	148	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
21	Diagnosis Code 5 UB	149	153	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
22	Diagnosis Code 6 UB	154	158	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
23	Diagnosis Code 7 UB	159	163	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
24	Diagnosis Code 8 UB	164	168	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
25	Diagnosis Code 9 UB	169	173	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
26	Diagnosis Code 10 UB	174	178	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
27	Diagnosis Code 11 UB	179	183	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
28	Diagnosis Code 12 UB	184	188	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.
29	Diagnosis Code 13 UB	189	193	5	Character	A secondary diagnosis code for the facility claim.	No decimal point.

30	Discharge Status Code UB	194	195	2	Numeric	The UB-92 standard patient status code, indicating disposition at the time of billing.	
31	Discount	196	205	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
32	Family ID	206	214	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
33	Gender Code	215	215	1	Character	The member's gender code.	"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
34	Line Number	216	217	2	Numeric	The detail line number for the service on the claim	
35	Net Payment	218	227	10	Numeric	The actual check amount for the record	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
36	Network Paid Indicator	228	228	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level	"Y" or "N"
37	Network Provider Indicator	229	229	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs	"Y" or "N"
38	Ordering Provider ID	230	242	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.	The ID should be the physician's Federal Tax ID (TIN).
39	PCP Responsibility Indicator	243	243	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	
40	Place of Service Code	244	245	2	Character	Client-specific code for the place of service.	Place of Service values will be identified in the Data **Dictionary.**
41	Procedure Code	246	250	5	Character	The procedure code for the service record.	CPT/HCPCS codes.
42	Procedure Code UB Surg 1	251	255	5	Character	The primary surgical procedure code (1) on the facility claim.	ICD-9 Surgical procedure codes.
43	Procedure Modifier Code 1	256	257	2	Character	The 2-character code of the first procedure code modifier on the professional claim	

44	Provider ID	258	270	13	Character	The identifier for the provider of service.	This must be the federal tax ID in order to use the standard hospital identifier lookup (UNIHOSP)
45	Provider Type Code Claim	271	273	3	Numeric	Client-specific code for the provider type on the claim record	Provider Type codes are further defined in the **Data Dictionary**
46	Provider Zip Code	274	278	5	Numeric	The 5-digit zip code corresponding to the Provider ID	Provider Location zip code
47	Revenue Code UB	279	282	4	Numeric	The CMS standard revenue code from the facility claim	This field must be at the service/detail level.
48	Third Party Amount	283	292	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Format 9(7)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
49	Units of Service	293	296	4	Numeric	Client-specific quantity of services or units	
50	Provider Name	297	326	30	Character	The description or name corresponding to the Provider ID.	
51	Financial Cost Amount	327	336	10	Numeric	The amount of payments contributing to total cost of coverage, but received as a standard claim.	Format 9(7)v99 (2 – digit, implied decimal) Usually used for capitation payments.
52	Capitation Type Code	337	338	2	Numeric	Client-specific code for the type of capitation payment	
53	Funding Type Code	339	340	2	Numeric	Specifies whether the claim was paid under a fully or self-funded arrangement	"S" = Self-funded "F" = Fully-funded
54	Account Structure	341	348	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Additional fields may be added to the layout if there is more than one component of the account structure.
55	Provider NPI Number	349	358	10	Character	The National Provider ID number for the provider.	
56	Provider Address 1	359	408	50	Character	The current street address1 of the provider of service.	
57	Provider Address 2	409	458	50	Character	The current street address2 of the provider of service.	
58	HRA Amount	459	458	10	Numeric	The amount paid from the HRA as a result of this claim.	
58	Filler1	469	599	131	Character	Reserved for future use	Fill with blanks
59	Record Type	600	600	1	Character	Record Type Identifier	Hard Code 'D'

Medical Detail – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction Notes
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record
4	Total Net Payments	31	44	14	Numeric	Total Net Payments on File	The sum of Net Payments provided on the file.
5	Filler	45	599	555	Character	Filler	Fill with Blanks
6	Record Type	600	600	1	Character	Record Type Identifier	Hard Code 'T'

MEDSTAT STANDARD DRUG FILE LAYOUT

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a Prescription Drug claims file for plan participants administered through **<Data Supplier>**.
The data will be provided in a fixed-record length, ASCII file format. The data request consists of two layouts/records; A Drug Detail Record and a Trailer Record.

METHOD OF SUBMISSION

[To be determined] Medstat supports a number of file submission options including: FTP, Web Submission, as well as physical media.

FREQUENCY OF SUBMISSION

The data will be submitted to Medstat on a **<monthly/quarterly>** basis.

TIMING OF SUBMISSION

<Monthly/Quarterly> files should be submitted on or before the 15th of the month following the close of each **<month/quarter>**.

Data Type: Drug Claims

Definitions:

- Prescription drug data are claim records for services that result in direct payment to a pharmacy on a service-specific (for example, prescription-specific) basis.
  Items for discussion

General

- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

Financial Fields
Medstat defines the relationship among financial fields as follows:

Charge Submitted
– Not Covered Amount*
= Charge Covered*
– Discount Amount
= Allowed Amount
– Coinsurance
– Copayment
– Deductible
– Penalty/Sanction Amount*
– Third Party Amount
= Net Payment

*not required in standard data extract (desirable if available)

Corrections to paid claims

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Medstat defines these as follows:

Void/Replacement
A void is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it. The original, void and replacement need not appear in the same file.

Example: After adjudication, a paid claim with a $25 Copay and $50 Net Pay, a correction was necessary. The correction contains a $10 Copay and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Void	-1	-75.00	-25.00	0.00	-50.00
Replacement	1	75.00	10.00	0.00	65.00

Adjustments
A financial adjustment is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well.
The original and adjustment need not appear in the same file.
Example: After a claim was adjudicated with a $25 Copay and $50 Net Pay, it was discovered that there should have been a $10 Copay and $65 Net Pay.

Record Type	Service Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	75.00	25.00	0.00	50.00
Adjustment	0	0	-15.00	0.00	15.00

Denied Claims
Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Medstat defines denied claims as follows:

- Fully denied claim - The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- Partially denied claim – The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

DATA FORMATTING

Character Fields

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

Numeric Fields

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

Financial Fields

- All financial fields should be right-justified and left zero-filled.
- Medstat prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string "1234567" would represent $12,345.67. Please do not include an actual decimal point in the data.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal) and left zero-filled.

Drug Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Medstat Fields							
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Adjustment Type values will be identified in the **Data Dictionary.**
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.	Format 9(7)v99 (2 – digit, implied decimal)
3	Capitated Service Indicator	12	12	1	Character	An indicator that this service (encounter record) was capitated	Applicable field values are "Y" for Capitated services and "N" for non-cap services.
4	Charge Submitted	13	22	10	Numeric	The submitted or billed charge amount	Format 9(7)v99 (2 – digit, implied decimal)
5	Claim ID	23	37	15	Character	The client-specific identifier of the claim.	
6	Claim Type Code	38	39	2	Numeric	Client-specific code for the type of claim	Claim Type Codes will be identified in the **Data Dictionary.**
7	Co-Insurance	40	49	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal)
8	Copayment	50	59	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.	Format 9(7)v99 (2 – digit, implied decimal)
9	Date of Birth	60	69	10	Date	The birth date of the person.	MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
10	Date of Service	70	79	10	Date	The date of service for the drug claim.	MM/DD/CCYY format

11	Date Paid	80	89	10	Date	The date the claim or data record was paid.	MM/DD/CCYY format This is the check date.
12	Days Supply	90	93	4	Numeric	The number of days of drug therapy covered by the prescription.	
13	Deductible	94	103	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.	Format 9(7)v99 (2 – digit, implied decimal)
14	Dispensing Fee	104	113	10	Numeric	An administrative fee charged by the pharmacy for dispensing the prescription.	Format 9(7)v99 (2 – digit, implied decimal)
15	Family ID	114	122	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.	The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
16	Formulary Indicator	123	123	1	Character	An indicator that the prescription drug is included in the formulary.	"Y" or "N"
17	Gender Code	124	124	1	Character	The member's gender code.	"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
18	Ingredient Cost	125	134	10	Numeric	The charge or cost associated with the pharmaceutical product.	Format 9(7)v99 (2 – digit, implied decimal)
19	Metric Quantity Dispensed	135	145	11	Numeric	The number of units dispensed for the prescription drug claim, as defined by the NCPDPD (National Council for Prescription Drug Programs) standard format.	
20	NDC Number Code	146	156	11	Character	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.	Please leave out the dashes.
21	Net Payment	157	166	10	Numeric	The actual check amount for the record	Format 9(7)v99 (2 – digit, implied decimal)
22	Network Paid Indicator	167	167	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level.	"Y" or "N"
23	Network Provider Indicator	168	168	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs.	"Y" or "N"
24	Ordering Provider ID	169	181	13	Character	The ID number of the provider who prescribed the drug.	The ID should be the physician's Federal Tax ID (TIN).

25	PCP Responsibility Indicator	182	182	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.	
26	Provider ID	183	195	13	Character	The identifier for the provider of service.	This must be the National Association of Boards of Pharmacy (NABP) number.
27	Rx Dispensed as Written Code	196	196	1	Character	The NCPDP (National Council for Prescription Drug Programs) industry standard code that indicates how the product was dispensed.	
28	Rx Mail or Retail Code	197	197	1	Numeric	The Medstat standard code indicating the purchase place of the prescription.	"M" for Mail, "R" for Retail
29	Rx Payment Tier	198	198	1	Character	Client-specific description for the payment tier of the drug claim.	Data Supplier will help Medstat understand which fields to use in order to set this field for the customer. Examples of Rx Payment Tier are as follows: 1. Generic 2. Brand Formulary 3. Brand Non Formulary
30	Rx Refill Number	199	202	4	Numeric	A number indicating the original prescription or the refill number.	This is the refill number, not the number of refills remaining.
31	Sales Tax	203	212	10	Numeric	The amount of sales tax applied to the cost of the prescription.	Format 9(7)v99 (2 – digit, implied decimal)
32	Third Party Amount	213	222	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).	Format 9(7)v99 (2 – digit, implied decimal)
33	Discount	223	232	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.	Format 9(7)v99 (2 – digit, implied decimal)
34	Provider NPI Number	233	242	10	Numeric	The National Provider Identifier for the pharmacy.	
35	Funding Type Code	243	244	2	Numeric	Specifies whether the claim was paid under a fully or self-funded arrangement	"S" = Self-funded "F" = Fully-funded
36	Account Structure	245	252	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Additional fields may be added to the layout if there is more than one component of the account structure.
37	HRA Amount	253	262	10	Numeric	The amount paid from the HRA to pay the provider.	
38	Filler1	263	399	147	Character	Reserved for future use	Fill with blanks
39	Record Type	400	400	1	Character	Record Type Identifier	Hard Code 'D'

Drug Detail – Trailer Record

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instruction Notes
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2004. This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2004 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data excluding the Trailer Record
4	Total Net Payments	31	44	14	Numeric	Total Net Payments on File	The sum of Net Payments provided on the file.
5	Filler	45	399	355	Character	Filler	Fill with Blanks
6	Record Type	400	400	1	Character	Record Type Identifier	Hard Code 'T'

ATTACHMENT F

HIPAA BUSINESS ASSOCIATE AGREEMENT TO COMPLY WITH PRIVACY AND SECURITY RULES

THIS BUSINESS ASSOCIATE AGREEMENT (hereinafter "Agreement") is between **The State of Tennessee, Access Tennessee Board of Directors** (hereinafter "Covered Entity") and **BlueCross BlueShield of Tennessee** (hereinafter "Business Associate"). Covered Entity and Business Associate may be referred to herein individually as "Party" or collectively as "Parties."

BACKGROUND

Covered Entity acknowledges that it is subject to the Privacy and Security Rules (45 CFR Parts 160 and 164) promulgated by the United States Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 in certain aspects of its operations.

Business Associate provides services to Covered Entity pursuant to one or more contractual relationships detailed below and hereinafter referred to as "Service Contracts"

- contract number(s) TBD

In the course of executing Service Contracts, Business Associate may come into contact with, use, or disclose Protected Health Information (defined in Section 1.8 below). Said Service Contracts are hereby incorporated by reference and shall be taken and considered as a part of this document the same as if fully set out herein.

In accordance with the federal privacy and security regulations set forth at 45 C.F.R. Part 160 and Part 164, Subparts A, C, and E, which require Covered Entity to have a written memorandum with each of its internal Business Associates, the Parties wish to establish satisfactory assurances that Business Associate will appropriately safeguard "Protected Health Information" and, therefore, make this Agreement.

DEFINITIONS

1.1 Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 CFR §§ 160.103, 164.103, 164.304, 164.501 and 164.504.

1.2 "Designated Record Set" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.3 "Electronic Protected Health Care Information" shall have the meaning set out in its definition at 45 C.F.R. § 160.103.

1.4 "Health Care Operations" shall have the meaning set out in its definition at 45 C.F.R. § 164.501.

1.5 "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

1.6 "Privacy Official" shall have the meaning as set out in its definition at 45 C.F.R. § 164.530(a)(1).

1.7 "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, subparts A, and E.

1.8 "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.9 "Required by Law" shall have the meaning set forth in 45 CFR § 164.512.

1.10 "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Parts 160 and 164, Subparts A and C.

2. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Privacy Rule)

2.1 Business Associate agrees to fully comply with the requirements under the Privacy Rule applicable to "business associates," as that term is defined in the Privacy Rule and not use or further disclose Protected Health Information other than as permitted or required by this Agreement, the Service Contracts, or as Required By Law. In case of any conflict between this Agreement and the Service Contracts, this Agreement shall govern.

2.2 Business Associate agrees to use appropriate procedural, physical, and electronic safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement. Said safeguards shall include, but are not limited to, requiring employees to agree to use or disclose Protected Health Information only as permitted or required by this Agreement and taking related disciplinary actions for inappropriate use or disclosure as necessary.

2.3 Business Associate shall require any agent, including a subcontractor, to whom it provides Protected Health Information received from, created or received by, Business Associate on behalf of Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to Protected Health Information, to agree, by written contract with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

2.4 Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.5 Business Associate agrees to require its employees, agents, and subcontractors to promptly report, to Business Associate, any use or disclosure of Protected Health Information in violation of this Agreement. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement

2.6 If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to provide access, at the request of Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524, provided that Business Associate shall have at least fifteen (15) days business days from Covered Entity notice to provide access to, or deliver such information.

2.7 If Business Associate receives Protected Health Information from Covered Entity in a Designated Record Set, then Business Associate agrees to make any amendments to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to the 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity, provided that Business Associate shall have at least thirty (30) days from Covered Entity notice to make an amendment.

2.8 Business Associate agrees to make its internal practices, books, and records including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for

purposes of determining Covered Entity's or Business Associate's compliance with the Privacy Rule.

2.9 Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosure of Protected Health Information in accordance with 45 CFR § 164.528.

2.10 Business Associate agrees to provide Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an Individual for and accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528, provided that Business Associate shall have at least fifteen (15) days from Covered Entity notice to provide access to, or deliver such information which shall include, at minimum, (a) date of the disclosure; (b) name of the third party to whom the Protected Health Information was disclosed and, if known, the address of the third party; (c) brief description of the disclosed information; and (d) brief explanation of the purpose and basis for such disclosure.

2.11 Business Associate agrees it must limit any use, disclosure, or request for use or disclosure of Protected Health Information to the minimum amount necessary to accomplish the intended purpose of the use, disclosure, or request in accordance with the requirements of the Privacy Rule.

2.11.1 Business Associate represents to Covered Entity that all its uses and disclosures of, or requests for, Protected Health Information shall be the minimum necessary in accordance with the Privacy Rule requirements.

2.11.2 Covered Entity may, pursuant to the Privacy Rule, reasonably rely on any requested disclosure as the minimum necessary for the stated purpose when the information is requested by Business Associate.

2.11.3 Business Associate acknowledges that if Business Associate is also a covered entity, as defined by the Privacy Rule, Business Associate is required, independent of Business Associate's obligations under this Memorandum, to comply with the Privacy Rule's minimum necessary requirements when making any request for Protected Health Information from Covered Entity.

2.12 Business Associate agrees to adequately and properly maintain all Protected Health Information received from, or created or received on behalf of, Covered Entity

2.13 If Business Associate receives a request from an Individual for a copy of the individual's Protected Health Information, and the Protected Health Information is in the sole possession of the Business Associate, Business Associate will provide the requested copies to the individual and notify the Covered Entity of such action. If Business Associate receives a request for Protected Health Information in the possession of the Covered Entity, or receives a request to exercise other individual rights as set forth in the Privacy Rule, Business Associate shall notify Covered Entity of such request and forward the request to Covered Entity. Business Associate shall then assist Covered Entity in responding to the request.

2.14 Business Associate agrees to fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Privacy Rule.

3 OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE (Security Rule)

3.1 Business Associate agrees to fully comply with the requirements under the Security Rule applicable to "business associates," as that term is defined in the Security Rule. In case of any conflict between this Agreement and Service Agreements, this Agreement shall govern.

3.2 Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic

protected health information that it creates, receives, maintains, or transmits on behalf of the covered entity as required by the Security Rule.

3.3 Business Associate shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information received from or created for Covered Entity or that carries out any duties for the Business Associate involving the use, custody, disclosure, creation of, or access to Protected Health Information supplied by Covered Entity, to agree, by written contract (or the appropriate equivalent if the agent is a government entity) with Business Associate, to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

3.4 Business Associate agrees to require its employees, agents, and subcontractors to report to Business Associate within five (5) business days, any Security Incident (as that term is defined in 45 CFR Section 164.304) of which it becomes aware. Business Associate agrees to promptly report any Security Incident of which it becomes aware to Covered Entity.

3.5 Business Associate agrees to make its internal practices, books, and records including policies and procedures relating to the security of electronic protected health information received from, created by or received by Business Associate on behalf of, Covered Entity available to the Secretary of the United States Department of Health in Human Services or the Secretary's designee, in a time and manner designated by the Secretary, for purposes of determining Covered Entity's or Business Associate's compliance with the Security Rule.

3.6 Business Associate agrees to fully cooperate in good faith with and to assist Covered Entity in complying with the requirements of the Security Rule.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in Service Contracts, provided that such use or disclosure would not violate the Privacy and Security Rule, if done by Covered Entity.

4.2 Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information as required for Business Associate's proper management and administration or to carry out the legal responsibilities of the Business Associate.

4.3 Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or provided that, if Business Associate discloses any Protected Health Information to a third party for such a purpose, Business Associate shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of Protected Health Information and not to use or further disclose such information except as Required By Law or for the purpose for which it was disclosed, and (b) notify Business Associate of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the Protected Health Information is breached.

4.4 Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

4.5 Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State Authorities consistent with 45 CFR 164.502(j)(1)

5. OBLIGATIONS OF COVERED ENTITY

5.1 Covered Entity shall provide Business Associate with the notice of Privacy Practices that Covered Entity produces in accordance with 45 CFR § 164.520, as well as any changes to such notice. Covered Entity shall notify Business Associate of any limitations in its notice that affect Business Associate's use or disclosure of Protected Health Information.

5.2 Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses.

5.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use of Protected Health Information.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy or Security Rule, if done by Covered Entity.

7. TERM AND TERMINATION

7.1 Term. This Agreement shall be effective as of the date on which it is signed by both parties and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, Section 7.3. below shall apply.

7.2 Termination for Cause.

7.2.1. This Agreement authorizes and Business Associate acknowledges and agrees Covered Entity shall have the right to immediately terminate this Agreement and Service Contracts in the event Business Associate fails to comply with, or violates a material provision of, requirements of the Privacy and/or Security Rule or this Memorandum.

7.2.2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

7.2.2.1. provide a reasonable opportunity for Business Associate to cure the breach or end the violation, or

7.2.2.2. if Business Associate has breached a material term of this Agreement and cure is not possible or if Business Associate does not cure a curable breach or end the violation within a reasonable time as specified by, and at the sole discretion of, Covered Entity, Covered Entity may immediately terminate this Agreement and the Service Agreement.

7.2.2.3. If neither cure nor termination is feasible, Covered Entity shall report the violation to the Secretary of the United States Department of Health in Human Services or the Secretary's designee.

7.3 Effect of Termination.

7.3.1. Except as provided in Section 7.3.2. below, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of, Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

7.3.2. In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction unfeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is unfeasible, Business Associate shall extend the protections of this Memorandum to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return

or destruction unfeasible, for so long as Business Associate maintains such Protected Health Information.

8. MISCELLANEOUS

8.1 Regulatory Reference. A reference in this Agreement to a section in the Privacy and /or Security Rule means the section as in effect or as amended.

8.2 Amendment. The Parties agree to take such action as is necessary to amend this Memorandum from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy and Security Rules and the Health Insurance Portability and Accountability Act, Public Law 104-191. Business Associate and Covered Entity shall comply with any amendment to the Privacy and Security Rules, the Health Insurance Portability and Accountability Act, Public Law 104-191, and related regulations upon the effective date of such amendment, regardless of whether this Agreement has been formally amended.

8.3 Survival. The respective rights and obligations of Business Associate under Section 7.3. of this Memorandum shall survive the termination of this Agreement.

8.4 Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity and the Business Associate to comply with the Privacy and Security Rules.

8.5 Notices and Communications. All instructions, notices, consents, demands, or other communications required or contemplated by this Agreement shall be in writing and shall be delivered by hand, by facsimile transmission, by overnight courier service, or by first class mail, postage prepaid, addressed to the respective party at the appropriate facsimile number or address as set forth below, or to such other party, facsimile number, or address as may be hereafter specified by written notice.

COVERED ENTITY:
Name: M.D. Goetz, Jr.
Title: Chairman, Access Tennessee Board of Directors
Address: 312 8th Avenue, North
Nashville, Tennessee 37243-0295
Phone: 615-253-8358
Fax: 615-253-8556
Email: dave.goetz@state.tn.us

BUSINESS ASSOCIATE:
Name: Tena Roberson
Title: Director, Legal Services & Assoc. General Counsel
Address: BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, TN 37402
Phone: (423) 535-5158
Fax: 423-535-4576
Email: tena_roberson@bsbst.com

All instructions, notices, consents, demands, or other communications shall be considered effectively given as of the date of hand delivery; as of the date specified for overnight courier service delivery; as of three (3) business days after the date of mailing; or on the day the facsimile transmission is received mechanically by the facsimile machine at the receiving location and receipt is verbally confirmed by the sender.

8.6 Strict Compliance. No failure by any Party to insist upon strict compliance with any term or provision of this Agreement, to exercise any option, to enforce any right, or to seek any remedy upon any default of any other Party shall affect, or constitute a waiver of, any Party's right to insist upon such strict compliance, exercise that option, enforce that right, or seek that remedy with respect to that default or any prior, contemporaneous, or subsequent default. No custom or practice of the Parties at variance with any provision of this Agreement shall affect, or constitute a waiver of, any Party's right to demand strict compliance with all provisions of this Agreement.

8.7 Severability. With respect to any provision of this Agreement finally determined by a court of competent jurisdiction to be unenforceable, such court shall have jurisdiction to reform such provision so that it is enforceable to the maximum extent permitted by applicable law, and the Parties shall abide by such court's determination. In the event that any provision of this

Agreement cannot be reformed, such provision shall be deemed to be severed from this Agreement, but every other provision of this Agreement shall remain in full force and effect.

8.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Tennessee except to the extent that Tennessee law has been pre-empted by HIPAA.

8.9 Compensation. There shall be **no** remuneration for performance under this Agreement except as specifically provided by, in, and through, existing administrative requirements of Tennessee State government and services contracts referenced herein.

IN WITNESS WHEREOF,

BLUECROSS BLUESHIELD OF TENNESSEE, INC.:

Tena Roberson 2/21/07

TENA ROBERSON, DIRECTOR LEGAL SERVICES **DATE:**

ACCESS TENNESSEE BOARD OF DIRECTORS

M.D. Goetz, Jr. 2-23-07

M.D. GOETZ, JR., CHAIRMAN **DATE:**

Contract Attachment G
BLUECARD PPO PROGRAM

G.1 This Attachment describes the general operation of the BlueCard/BlueCard PPO Program and describes the responsibilities of Contractor and State in relation to methods of paying claims and the fees and allowances resulting from administration of the BlueCard/BlueCard PPO Program. Contractor is referred further in this Attachment as a "Home Plan."

G.1.1 Like all BlueCross and BlueShield Licensees, Contractor participates in a program called "BlueCard." Whenever Members access health care services outside the geographic area Contractor serves ("Service Area,") the claim for those services may be processed through BlueCard and presented to Contractor for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies.")

G.1.2 Under BlueCard, when Members receive covered health care services within the geographic area served by an on-site BlueCross and/or BlueShield Licensee ("Host Plan,") Contractor remains responsible to State for fulfilling Contractor's contract obligations. However, the Host Plan will be responsible, in accordance with applicable BlueCard Policies, if any, only for providing such services as contracting with its participating providers and handling all interaction with its participating providers. The financial terms of BlueCard are described generally below.

G.2 Liability Calculation Method Per Claim. The calculation of Members' liability on claims for covered health care services incurred outside Contractor's Service Area and processed through BlueCard will be based on the lower of the provider's billed charges or the negotiated price Contractor pays the Host Plan.

G.2.1 The calculation of State's liability on claims for covered health care services incurred outside Contractor's Service Area and processed through BlueCard will be based on the negotiated price Contractor pays the Host Plan.

G.2.2 Methods used to determine a negotiated price will vary among Host Plans, depending on the terms of each Host Plan's provider contracts. The negotiated price that Contractor pays a Host Plan on a health care claim processed through BlueCard may represent:

G.2.2.1 the actual price the Host Plan paid to the health care provider ("Actual Price"); or

G.2.2.2 an estimated price, determined by the Host Plan in accordance with BlueCard Policies, based on the Actual Price adjusted to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Plan's health care providers, or one or more particular providers ("Estimated Price"); or

G.2.2.3 an average price, determined by the Host Plan in accordance with BlueCard Policies, based on a billed charges discount representing the Host Plan's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of the Host Plan's health care providers, or for a specified group of providers ("Average Price.") An Average Price may result in greater variation to the Member and Employer from the Actual Price than would an Estimated Price.

G.2.3 Host Plans using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively adjust the Estimated Price or Average Price to correct for overestimation or underestimation of past prices. However, this prospective adjustment will not affect the amount the Member and State pay, which BlueCard defines as a final price.

G.2.4 Use of the Estimated Price or Average Price calculation method may result in the Host Plan's holding some portion of the amount the Employer pays in a variance account, pending settlement with the Host Plan's participating providers. Since all amounts paid are final, the funds held in a variance account (if any) do not belong to State. These funds are eventually exhausted by provider settlements and through prospective adjustment to the negotiated prices.

G.2.5 Statutes in a few states may require a Host Plan either to:

G.2.5.1 use a basis for calculating Member liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim; or

G.2.5.2 add a surcharge.

G.2.6 If any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Contractor would then calculate Member liability and Employer's liability for any covered health care services consistent with the applicable state statute in effect at the time the Member received those services.

G.3 Return of Overpayments. Under BlueCard, recoveries from a Host Plan or its participating providers can come from anti-fraud and abuse audits, provider audits, credit balance audits, utilization review refunds, and unsolicited refunds, among other sources. Host Plans may use third parties to assist in discovering or collecting recovery amounts. The third party's fees are netted against the recovery. Recovery amounts, net of fees (if any), will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

G.4 BlueCard Fees and Compensation. State understands and agrees:

G.4.1 to pay certain fees and compensation to Contractor, as contained in Section A.1.3.1 of the contract, which Contractor is obligated under BlueCard to pay to the Host Plan, to the BlueCross BlueShield Association ("BCBSA,") or to BlueCard vendors, unless our contract obligations to the State require those fees and compensation to be paid only by Contractor; and

G.4.2 that BCBSA may revise fees and compensation under the BlueCard program from time to time without Employer's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Contractor will notify the State as soon as practicable if these fees and compensation arrangements are modified.

G.4.3 Some of these fees and compensation arrangements are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Some of these claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to Employer as an additional claim liability.

G.4.4 Other fees include, but are not limited to, an 800 number fee and a fee for providing PPO provider directories. If you do not have a complete listing, or want an updated listing of these types of fees or the amount of these fees paid directly by the State, you should contact Contractor. All such applicable fees are listed in section A of this Contract.

G.4.5 The claim-based access fee, if one is charged, will not exceed 4.36% of the discount received from the Host Plan on such claim, or no more than $2,000 per claim.

G.5 Administrative Expense Allowance Fees. The BlueCard/BlueCard PPO Program provides that Contractor or other Home Plan must pay the Host Plan an Administrative Expense allowance for each Original Claim that the Host Plan processes. The amount of the Administrative Expense Allowance is determined according to the terms of the BlueCard/BlueCard PPO Policies and Procedures and varies according to the type of claim processed. Current Administrative Expense Allowance charges are as follows:

Type of Claim	State's cost per Claim	
	Standard	Large Group Locations
Professional Claim	$5.00	$4.00
Institutional Claim	$11.00	$9.75

*Large Group Locations are defined as: (1) Accounts having 1,000 or more, up to 9,999, Subscribers in a PPO product with 20 or more Subscribers residing in a single Host Plan Service Area; or (2) Accounts having 10,000 or more Subscribers in a PPO product. The State is considered a large group.

G.6 Access Fees. A Host Plan can charge an Access Fee only if the Host Plan's contract with the provider requires that the provider accept the payment rate negotiated by the Host Plan as payment in full for the services provided. The provider cannot seek to recover from the Member any amount above the Host Plan's payment rate except for applicable deductibles and copayments. When a Host Plan charges an Access Fee, the Host Plan certifies that it has an enforceable agreement with the provider that holds the Member harmless from balance billing and that the Host Plan will enforce such agreement.

G.7 BlueCard Worldwide. Through the BlueCard Worldwide Program, Members also have access to a participating hospital network and referrals to doctors in major travel destinations throughout the world. When Members need to locate a hospital or doctor, they can call 1.800.810.BLUE, or call collect at 1.804.673.1177; they can also visit the web site***https://international.worldaccess.com/bcbsa/index.asp?page=login,*** or they can call Contractor. When Members need inpatient medical care, they should call the BlueCard Worldwide Service Center, who will refer them to a participating hospital. Members will only be responsible for the Plan's usual out-of-pocket expense (i.e., non-covered expenses, deductible, copayment and/or coinsurance). In an emergency, Members should go to the nearest hospital. The BlueCard Worldwide Service Center will also provide referrals to doctors, but Members will have to pay the provider and then file the claim for reimbursement. The administrative costs charged by the BlueCard Worldwide Program will be passed on to the State when they are received by Contractor.